Medicare Fee-For-Service (FFS) Functional Environment

CMS' plan for implementing the Medicare contracting reform provisions contained in section 911 of the Medicare Modernization Act is designed to achieve strategic goals for Medicare FFS administrative operations. The major strategic goals are:

- Consolidation of claims workload and systems to further ensure accurate and timely payment of claims and to achieve economies of scale for processing larger workloads;
- Integration of Medicare Part A and Part B claims processing and information technology (IT) modernization to achieve patient-centered benefit administration and establish a single point-of-contact for health care providers;
- Compensation of administrative contractors commensurate with performance and accountability;
- Specialization of contracts to align scarce resources with important benefit administration functions; and
- Optimization of contractor management and oversight to improve the overall functioning of the Medicare program.

The initial implementation phase, scheduled for 2005-2011, will focus on implementation of the Medicare Administrative Contractors (MACs) as well as other FFS initiatives. The result of the combined initiatives will enable CMS to improve Medicare's administrative structure by having a future FFS environment that has:

- MACS which will assume work currently performed by fiscal intermediaries and carriers, and serve as health care providers' primary point-of-contact for the receipt, processing and payment of claims;
- Functional contractors which will perform work around a single Medicare program function, such as claims appeals, and provide increased efficiency in the management and delivery of services to beneficiaries and providers; and
- IT improvements to bring about integrated IT systems that will improve overall processing of claims and allow providers to not only electronically submit claims, but also check beneficiary eligibility and claims payment status

In the future FFS environment under Medicare Contracting Reform, CMS will contract with MACs to provide administrative services to beneficiaries and health care providers. CMS will conduct full and open competitions for MACs, looking for best value and innovation in addition to technical expertise and ability to meet requirements. At the same time, CMS will maintain its relationship with existing functional contractors that have increased the efficiency of Medicare services for beneficiaries and providers. These functional contractors include the program safeguard contractors (PSCs) and qualified independent contractors (QICs) for Medicare appeals. In the future CMS will implement additional functional contractors, including beneficiary contact centers and data centers, which will also bring benefits to beneficiaries and providers.

Qualified Independent Contractors
In accordance with the law, CMS has contracted with QICs to provide a second-level of appeal, reviewing redeterminations made by FIs and carriers. QICs will achieve improvements in fairness, consistency, and efficiency of the appeals process. These improvements follow from a more independent process, greater reliance on physician reviews, standard protocols, and an improved data system.

Program Safeguard Contractors
CMS created PSCs under the authority of the Medicare Integrity Program (MIP) to give greater focus to program safeguard activities: the review of provider activities, including medical, utilization, and fraud reviews; cost report audits; Medicare secondary payer determinations; and provider and beneficiary education regarding program integrity. Although the MMA allows MACs to be awarded contracts that include MIP functions, CMS expects PSCs will perform several of these activities in the future FFS environment, coordinating closely with the MACs.

Beneficiary Contact Centers
CMS currently is conducting a procurement for new Beneficiary Contact Centers (BCCs) which will serve as a single Medicare point-of-contact for beneficiaries. By calling 1-800-MEDICARE, beneficiaries will be connected to a seamless network of customer service entities that can answer Medicare and related questions and resolve problems. Claims-specific inquiries will be routed to the BCCs, which will be operated by companies under contract with CMS.

Data Centers
CMS will consolidate data centers from the current level of 14 to 4 and contract directly with them for claims processing support. Data center consolidation will enable CMS to increase its control of data center operations and secure protected health information more effectively. It will also enable the creation of Web-based services and increase access to quality data, integrated help desks, and call centers.

Medicare Fee-For-Service Program
Administrative Functional Environment